Codify
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Dermatology Coding Alert

You Be the Coder: Layered Closure After Melanoma Excision

Question: Following a melanoma excision, our surgeon performed a layered closure. I've heard that we should add the dimensions of the lesion excision to determine the code choice for the closure -- this correct?

New Mexico Subscriber

Answer: No, you should not base the closure code on the lesion excision size at all. Instead, you should base it on the closure size. When the surgeon excises a lesion, the code includes simple (single layer) closure. But if the surgeon performs a layered closure as you described, you can separately bill the intermediate closure.

Do this: What you need to know to bill the closure is the longest dimension of the wound. This is likely to be quite a bit longer than the excision itself, because surgeons often create an elliptical excision, which is needed for a clean closure. You will identify the total length of the repair and choose the intermediate repair code that matches that length.

For instance: The surgeon creates an elliptical excision 6 cm long surrounding a 2.5 x 1.5 x 1.0 cm lesion excision with 1 cm margins on the scalp. You should report the intermediate repair as 12032 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 2.6 cm to 7.5 cm) in addition to the excision code (11604, Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 3.1 to 4.0 cm).

These rules for closure coding apply for excision of benign and malignant lesions of both the integumentary system (114xx -- 116xx) and the musculoskeletal system for lesions such as lipomas (for example, 21011, Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm). The only difference is that you can only separately report complex repair with muscle/soft tissue lesions, while you can separately report intermediate and complex repair with integumentary lesions.